Care of Old People: A Framework for Progress

1. INTRODUCTION

1.1 The working party was asked by the College to provide a framework of clinical care for elderly patients in general practice. As there are many aspects of such care and many changes are currently taking place, it was a wide remit. Increasing numbers of old people, particularly the very old, changes in society, the emphasis the Government is placing on the care of old people in the community, and the new contractual arrangements for general practitioners combine to make care of the elderly a major challenge to general practice in the United Kingdom in the 1990s.

1.2 Many demands are made on general practitioners and there is no limit to the tasks which can be assigned to them. Inevitably all practices are concerned with the care of old people. The purpose of this report is to help each practice to plan the care they wish to provide for their elderly patients. Specific recommendations will be made about the ways in which health care for old people in the community can be organized, and criteria of good practice put forward.

1.3 Before doing this, however, it is necessary to describe the changing scene, and make certain definitions. The challenge posed by the health needs of old people will be identified and areas of concern stated. The first part of the report will therefore be concerned with context and the second with practice.

1.4 For the purpose of the report an old person is someone over the age of 65 years: the words old, older, elderly, are used synonymously and do not indicate any chronological difference.

2. THE CHANGING SCENE

2.1 Society is experiencing rapid changes both in demography and the health, social and economic status of old people. There is an improving understanding of the natural history of ageing and the characteristics of illness in old age. Recent Government initiatives (Secretaries of State, 1989a and b) will have dramatic effects on the way in which medical and social care are delivered in the community.

2.2 During the past three decades the number of over 65-year-olds in England and Wales has increased both in absolute terms and as a proportion of the total population (Figure 1). There will soon be a peak in the number of old people over the age of 65 years, but during the next decade the number of over 75-year-olds and over 85-year-olds will continue to increase and so form a higher proportion of the elderly population (Figure 2). This increase in the number of very old people will have major implications for general practice, because it is this group which has the highest levels of disability and therefore the greatest need for health and social services (OPCS, 1988). Ageing is a variable process and biological age does not necessarily equate with chronological age (Rowe and Kahn, 1987). Old people form an extremely heterogeneous group and it is important for health care to be sensitive to each individual's needs.

2.3 It is difficult to provide a clear statement of the health status of old people. The three National Morbidity Studies carried out in general practice measured morbidity but not health (RCGP *et al.*, 1986). Despite the heterogeneity mentioned earlier, there is some evidence that there are changes in health as age advances (Taylor and Ford, 1983). However, most people between 65 and 75 years are reasonably healthy (Luker and Perkins, 1987), but as age advances there is a measurable decline in mobility and in the ability to perform personal and domestic tasks

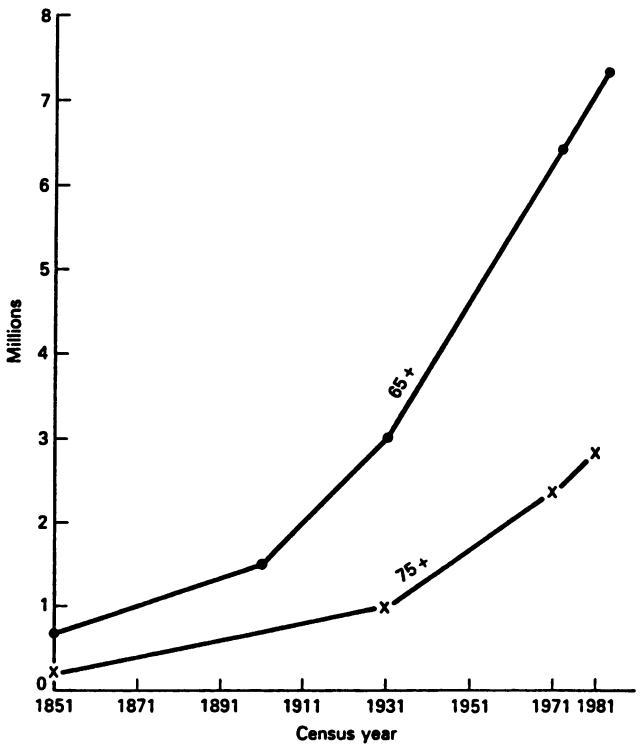

Figure 1. Population trends over the last century (England and Wales).

Source: After Smith (1988) using data from censuses for 1851–1981. In Williams (1989) *Caring for Elderly People in the Community.* Figure 2.1. 2nd ed. Chapman and Hall, London. Reproduced with permission.

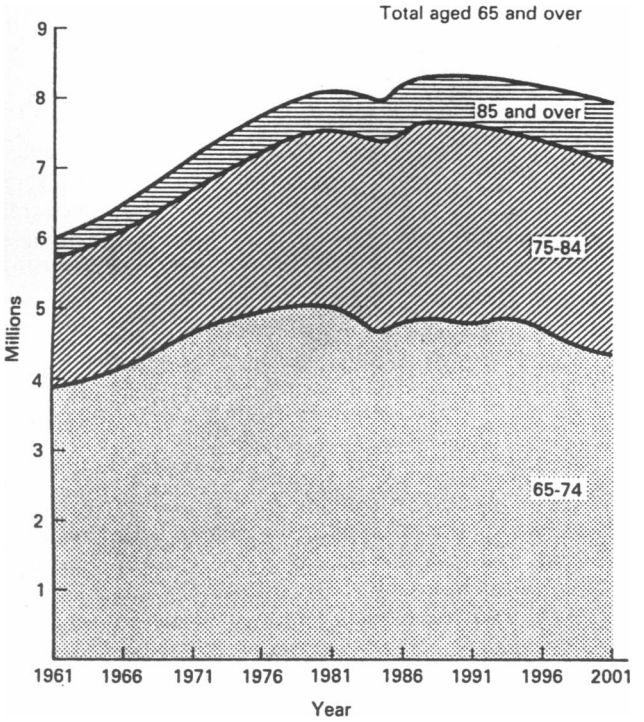

Figure 2. Population prediction.

Source: Department of Health and Social Security (1981) *Growing Older.* Cmnd 8173. Chart A. London, HMSO. Reproduced with permission.

(Hunt, 1978). The existence in the elderly of a reservoir of unreported health need is well documented (Williamson *et al.*, 1964; Williams *et al.*, 1972; Barber and Wallace, 1976; Vetter *et al.*, 1986; Ebrahim *et al.*, 1987).

2.4 There have been major changes in the social circumstances of older people during the past two decades. Smaller family sizes and the dispersal of the extended family mean that old people are now less likely than in previous generations to have support and care from their own children (Gruer, 1975; Hunt, 1978). Nevertheless, the main carers of disabled elderly people in the community continue to be immediate family members. Although most elderly persons live in one generation households as a married pair, a sizeable minority live in the same household as their children (Hunt, 1978). A third of old people live alone, and this proportion rises to over one half in women over the age of 85 years. Women outnumber men in old age. It is now unusual for anyone to remain in paid employment after the age of 65 years. Old people are important users of public transport (Abrams, 1983). Special housing for older people, increasing numbers of private nursing homes and retirement to coastal areas are creating communities which have very high levels of elderly people, with consequent high demand for health and social services (Williams, 1989).

2.5 In old age there are many unusual manifestations and atypical presentations of illness. Hypothermia, subnutrition, dehydration and drug sensitivity, individually or in combination, can make accurate diagnosis difficult. Multiple disability is common and although individually some problems may appear minor, collectively they produce an accumulative loss of function. The effect of illness upon function is of key importance to old people.

2.6 Psychological changes also occur in old age. Some are negative, reflecting a loss of status on retirement, which can lead to withdrawal and isolation; but many are positive and relate to financial security and the opportunity to fulfil ambitions previously denied. Commonly held negative stereotypes of old people being inflexible and obstructive are not supported by evidence.

2.7 A recent change has been the expansion of private nursing and residential establishments for elderly people. The number of independent or private nursing homes increased slowly until 1980, when there were 34 500 places in all categories of nursing homes, including private hospitals. Between 1980 and 1984 nearly 6000 additional places were added and 300 new private nursing homes and hospitals were opened, with an increase in bed capacity of 17%. In England there were about 32 000 places in private rest homes in 1979, but by December 1984 there were an estimated 77 000 places. This represents an increase of about 140% in just under five years (Smith, 1987). This has meant a shift in the provision of long-term care for frail elderly people from the hospital to the community. This has happened largely in an unplanned way, and places on the general practitioner added responsibilities. Problems arise in providing general practitioner care and arranging appropriate assessment on entry.

2.8 The Government White Papers on health care and social care *Working for Patients* (Secretaries of State, 1989a) and *Caring for Patients* (Secretaries of State, 1989b) and the new contract for general practitioners (Department of Health, 1989) will have far-reaching effects on the provision of health and social care for old people in the community.

3. THE CHALLENGE TO GENERAL PRACTICE

3.1 The changes described have created a need to reconsider the ways in which care of the elderly in the community is provided. This has been given further urgency by Government policy which has for some time been to provide as much care as possible for old people in their own homes (DHSS, 1983). This presents a major challenge for general practice.

3.2 Fortunately general practitioners are well placed to respond to the needs of the elderly. Their role is familiar, and compared with health visitor and social worker, old people are more likely to identify with 'their doctor'. General practitioners are the gatekeepers to most other services, and are contracted to provide a 24-hour, 7-day week service. General practitioners have the highest professional contact rate with

the frail elderly in the community (Hunt, 1978). In terms of medical care, 90% of health needs in the National Health Service are now dealt with by the primary care services. *General Household Survey figures show consistently that the contact rate between general practitioners and over 75-year-old patients is as high as 6 per year. More than half of the contacts in this age group between doctor and patient are at home.*

3.3 General practitioners also have the advantage of being part of a team, and the response of general practice needs to be seen in the context of other health and social services available in the community. The interplay of physical, psychological and social factors is of particular importance in maintaining the health of older people. One profession in isolation cannot hope to fulfil the health needs of people in this age group. The idea of the team is a wide one, and may be more appropriately described as a network. Patients themselves and their carers are the centre of this network. The prime carer is usually, but not always, a relative.

3.4 The formal network consists of a wide range of people with a variety of skills. Staff directly employed by general practitioners include practice managers, receptionists, secretaries and practice nurses.

3.5 Not all practices employ their full quota of staff, and many do not have nurses. An important development may well be an increase in the number of staff employed in a practice, and a widening of the disciplines involved, for instance more counsellors and physiotherapists.

3.6 The health authority also provides services for elderly people in the community. Many practices have attached district nurses and health visitors. The future pattern of community nursing and health visiting, however, remains uncertain following the Cumberlege Report (1986). Many health visitors still do not have much contact with the elderly. Geriatric liaison nurses, stoma nurses, physiotherapists, remedial gymnasts, occupational therapists and speech therapists are all important members of the network, and work closely with others in providing health care. Consultant geriatricians, through the domiciliary visiting services, can provide support for general practitioners and access to day hospitals.

3.7 Social care resources include social workers, home care assistants, meals on wheels, luncheon clubs, provision of aids and appliances, day centres, welfare homes, sheltered accommodation, laundry services, help with heating, diet and special help for the blind. The private sector is increasingly providing long-stay accommodation for the elderly, and voluntary organizations and self-help groups are involved in providing care for the elderly who remain in their own homes.

3.8 Good communication between the different agencies and individuals involved in care is vital, older people themselves needing to have accurate information about the services which are available to them. The response of general practice has been to provide a high level of service to older people in the community, both directly and in conjunction with other agencies. Nevertheless, there are gaps and weaknesses in the health care provided for old people and the next section of this report addresses this problem.

4. AREAS OF CONCERN

4.1 Introduction

4.1.1 At present fragmentation, overlap and variability characterize the services provided for older people. Health authorities, general practitioners, social services departments and the voluntary agencies find it difficult to co-ordinate the services they provide. Each has its own budget and covers areas which are not coterminous. Team cohesion may be difficult, because individuals who are seeking to work together in providing care to individual patients have to relate to different employers, and are subject to different policies.

4.1.2 Within general practice, wide variation between practices is apparent when examining the pattern of services provided for older people. The Manchester workload study (Wilkin and Williams, 1986) demonstrated the wide variation that exists between practices in consultation rates, home visiting rates and referral rates for older people. As yet, information systems in most general practices are at a rudimentary level, and it is not possible to determine the extent to which variations in crude consultation rates are mirrored by variations in the quality of care provided.

4.1.3 Some generalizations about the patterns of care provided for old people in general practice are valid. Ford and Taylor (1985) have shown that the failure to detect health problems in the elderly is not due to underconsulting. Most older people see their doctor at least once a year, and it has been shown that most of those who are not in regular contact with their general practitioner are well (Williams, 1984; Ebrahim *et al.*, 1984).

4.1.4 Existing high levels of contact between general practitioners and the elderly do not guarantee the detection of unreported disability and indicate the necessity for health assessments with a defined and agreed content. Without such definition the intention of both Government and the profession of implementing medical audit will have little impact on the actual quality of care provided for older people (Buckley and Williamson, 1988).

4.1.5 Although general practitioners are aware of the existence of unmet health needs in their elderly patients, planned systematic programmes of anticipatory care for old people remain the exception in general practice (Williams, 1983). The work of general practitioners remains essentially reactive. A previous report has emphasized the need to shift the emphasis of prevention into specific proposals for general

practitioners to assess and examine older patients who are aged 75 years and over (Taylor and Buckley, 1987). General practice has been slow to respond, particularly because of the feeling that no evidence existed in favour of such anticipatory care, despite recent reports to the contrary (Hendriksen *et al.*, 1984; Vetter *et al.*, 1984). There has also been a concern that preventive activity could divert resources from other ways of providing health care for elderly people.

4.1.6 Before making specific recommendations about the ways in which health care of old people can be improved in general practice, it is necessary to consider the constraints which impede progress. Because general practice provides a comprehensive service, it is inevitable that there will be competing demands for time and resources. Patient, doctor and team factors contribute to these constraints and they have to be recognized if an effective primary health care service for old people in the community is to be implemented.

4.2 Patient constraints

4.2.1 In spite of the major changes which have taken place in society and in medicine over the past two decades, the expectations of old people themselves about their health and the services they should receive remains low (Williams and Fitton, 1990). This may reflect values and attitudes formed before the National Health Service was created, but a more likely explanation is that elderly people have not had access in the past to sufficient information about health, the normal processes of ageing, what general practitioner services are available, how to make the best use of such services, and what sort of symptoms and problems it would be useful to consult the doctor about. With better information for patients and the further development of patient participation groups attached to general practices, the low expectations of elderly people will improve. Fortunately, the majority of elderly people are healthy (Hunt, 1978) and many have a positive approach to ageing.

4.2.2 When looking for consumer views in advocating the case of old people, it has sometimes been difficult to find representative opinion. Patient participation groups have proved to be a good forum for expression of such opinion. There are relatively few practices, however, with these groups, but their formation would help both in passing information to elderly patients and their carers and receiving in return patients' views about their needs.

4.2.3 Organizations such as Age Concern and Help the Aged are concerned with the needs of all old people and have been particularly concerned with developing high quality general practitioner services. The establishment of the British Association of Retired Persons has also been an important development in representing the needs of a wide range of older people.

For the present, however, because of lack of information, an important barrier to care can be older people themselves. When they see their health problems as being the inevitable consequence of ageing and are apologetic for bothering the doctor, much that is treatable is put down to old age and old people are selective in the problems they present for medical attention. This is a form of 'ageism' which is a major barrier to good care. Again, because of lack of information, professional carers, friends, relatives and older people themselves can collude in perpetuating this problem.

4.3 Doctor constraints

4.3.1. There is evidence that general practitioners and other health workers feel positive about working with older people but have reservations about the effect of their interventions (Buckley, 1989). It is a particular cause for concern that attitudes towards working with older people appear to become less positive as medical students and young doctors proceed through training (Gale and Livesley, 1974). Many general practitioners and health visitors already feel overwhelmed by their present level of workload in caring for older people. Their work remains mainly reactive and as most of the problems presented by older patients are significant, the value of this type of care must be recognized.

4.3.2 The feelings of ambivalence about the effectiveness of detecting unreported disability in the elderly has meant that systematic programmes of anticipatory care in general practice are the exception rather than the rule (Williams, 1983). In order for such programmes to be implemented on a wide scale, these feelings have to be recognized and fears overcome. This can be done by the provision of courses for general practitioners and also by demonstrating ways in which proactive health care for old people can be both effective and easily incorporated into working practice.

4.3.3 The educational implications are considerable. Medical education still reflects the disease model with an emphasis on investigation and surgical or pharmacological management rather than functional improvement.

4.3.4 The independence of general practitioners is a strength when doctors are acting as advocates for their patients and when implementing new and better services. It can be a constraint to progress if doctors use their independence to resist change. A valuable tool in effecting change is medical audit, but this has not been widely used for assessing health care of elderly patients.

4.3.5 Older people take more prescribed medicine than those in younger age groups, and published evidence about prescribing for the elderly indicates room for improvement (Shaw and Opit, 1976; Bliss, 1981). Over the age of 65 more than half the population takes

at least one prescribed medicine on a regular basis, and elderly people also consume a similar amount of over-the-counter medications. Multiple medications, poor memory, poor vision, impaired dexterity, poor hepatic and renal function can all contribute to produce problems with medicines. Pharmacological advances have improved the treatment possibilities for many older patients, and regular prescribing is necessary in a population where degenerative cardiorespiratory and joint disease are to be expected. These drugs can improve the quality of life in people dramatically. Nevertheless, a study by Cartwright and Smith (1988) reports a 27% rise in prescribing for old people between 1977 and 1985, and identifies weaknesses in the instructions given to patients, record keeping and the monitoring of long-term medicine taking. Clearly there are many patients who could and should be on fewer medicines, but arguments should be based on an informed view and not one that suggests that the dimensions of the prescribing problem are greater than they really are (Freer, 1985).

4.4 Team constraints

4.4.1 The increasing needs of the elderly population have resulted in the need to re-examine the structure and function of the primary health care team. Teams function in different ways in different locations. While this may be an advantage in showing the way in which the primary health care team adapts to the needs of different communities, it also reflects the uncertainty about the roles of team members. This is exemplified by the wide variations which exist between health visitors in the amount of time they devote to the assessment of older people. Although the Health Visitors Association now places high priority on the work of health visitors with older people, on average the proportion of time health visitors spend on this activity has not increased over the past ten years (Luker, 1987). Perhaps as a consequence in different parts of the country general practitioners, practice nurses, district nurses, lay volunteers and occupational therapists have taken the lead in assessing the health needs of older people (Goble *et al.*, 1979).

4.4.2 Absence of nationally agreed policies has led to confusion in the way different team members contribute to care for the elderly. The provision of social support is a good example of difficulties in communication leading to care failure. Problems faced by elderly patients who are discharged from hospital are also often due to failure in team co-operation (Williams and Fitton, 1988). In a health centre, poor working practices by receptionists and secretaries can result in poor access to services by old people. The provision of long-term residential care for older people has changed dramatically in recent years and the delivery of care to these homes has raised difficulties for the team, for instance in the provision of nursing care. The increasing importance of informal carers in the community has necessitated an awareness of their needs by health and social workers.

5. NEW DEVELOPMENTS

5.1 Several important policy documents have recently been published: the White Papers *Promoting Better Health, Working for Patients,* and *Caring for People* (Secretaries of State, 1987, 1989 a,b) and the new contract for general practitioners (Department of Health, 1989). Each has important implications for care of the elderly. The White Paper on the Health Service sets out to promote better health care through greater choice of services for the patient and increased accountability of doctors and other providers of health care. An important proposal which encourages greater financial control and accountability for general practitioners is that larger practices will have an opportunity to manage their own budgets.

5.2 The new contract makes specific proposals which concern the elderly. Doctors will receive a higher capitation fee for patients on their list who are 75 years of age or over. This higher capitation fee is meant to pay for the work entailed in screening and caring for older people in the community. This is the first time that a list of clinical procedures has been made part of the contractual requirements for general practitioners in the National Health Service (Table 1). The implications of these changes for the work of general practitioners remain unclear.

5.3 The profession has welcomed proposals for implementing medical audit. Evaluating the effectiveness of surveillance programmes for the elderly in general practice is essential. Evaluation should also consider the use of professional time, costs and use of resources and the views of patients. Any development in health care which requires health professionals to use their time in a new way has costs as well as possible benefits. Time spent visiting fit elderly people might be better spent dealing with people presenting with symptoms in the surgery.

5.4 The profession and the Government share a common aim in trying to improve the health care of older people. What is at issue is whether the new contract for general practitioners will achieve this aim. There is concern about the increase in the proportion of the pay of general practitioners which comes from capitation fees. Doctors may prefer to take on to their list young healthy patients in preference to older people, particularly if they are worried about keeping within their

Table 1. Checks required by the new contract on over 75-year-old patients.

- Sensory functions
- Mobility
- Mental condition
- Physical condition including continence
- Social environment
- Use of medicines

indicative drug budget. There are also concerns about the new contract on ethical grounds. People young and old may have objections about being contacted by health workers. There is evidence that health checks in younger people can engender anxiety. Most older people welcome contact with nurses and doctors but care should be taken lest enthusiasm for health promotion intrudes into patients' rights for privacy and non-participation.

5.5 The White Paper *Caring for People* acknowledges the key role played by general practitioners in caring for the disabled, most of which are elderly. What is not given in the text are the details of the doctor's responsibilities and the mechanisms which will exist to meet them. How far existing responsibilities are to be extended is unclear. The White Paper on the National Health Service lays down provisions for universal care, for example health checks for all over 75-year-olds, whereas the White Paper on community care seems to be more concerned with targeting. This raises concern about ethics, workload, priority setting and opportunity costs. In relation to the elderly, plans from social services departments are still not available. It is unclear who will have the lead role; general practitioners should be involved in discussions that determine this. The question of ring fencing of social services funding will be of crucial importance.

5.6 The medical care of residents in nursing homes already places a considerable workload on some practices. The number of older people in various types of supported accommodation in the community is likely to rise still further. General practitioners should contribute to the multidisciplinary assessment of old people being considered for continuing care in residential or nursing homes. They also should be involved in the early planning phases of the building and siting of such accommodation. The laudable concept of providing care in the community for the chronically disabled and handicapped has not been matched by an investment in personnel in the community to meet their health and social needs. The effects of the Government's proposals need to be monitored and evaluated.

6. ACHIEVING GOOD PRACTICE

6.1 Introduction

6.1.1 When considering an area as complex as health care of the elderly, it is not easy to distil the essence of good care into a few short sentences. All statements about good practice must of necessity be realistic and practical. There is general agreement that the overall aim of primary health care for older people is to help them *function effectively* in the environment of their own choice. Most people want to live in their own homes, but sometimes people want to live in some form of sheltered care, and this must be recognized. A second major aim for general practice is that the arrangements for care should be so organized that old people can make use of them effectively. A more detailed list of objectives which may be useful to a practice or primary health care team when planning care for old people is given in Table 2. A checklist for undertaking a practice review is detailed in Table 3.

Table 2. Objectives of general practice care of old people.

1.	To maintain and where possible improve the quality of care provided for elderly people by a regular programme of medical audit
2.	To keep abreast of new developments in health care by a commitment to continuing medical education
3.	To take into account old peoples' problems in gaining access to the available services provided by the practice
4.	To strive to reach accurate diagnoses on which logical treatment and realistic prognoses can be based
5.	To provide effective continuing care for those with long-term medical problems and chronic illness
6.	To offer a systematic programme of anticipatory health care for older people
7.	To contribute to the resettlement of patients who are discharged from hospital or other institutions back into the community
8.	To provide sensitive and effective care for the dying patient
9.	To develop and participate in a team approach to the provision of the care of elderly persons
10.	To provide information and health education for older people in a practice
11.	To support the informal carers with the aim of preventing breakdown
12.	To further the interests of old people and when necessary act as their advocate

6.1.2 A helpful guide is the Age Concern publication *General Practitioners and the Needs of Older People* (1986a), and its companion paper, *Meeting the Needs of Older People* (1986b).

6.1.3 The ideas of Donabedian (1986) concerning the structure, process and outcome of care have been widely accepted as providing a logical framework for considering the quality of care in general practice. This report will use this framework to look at the different elements which are required to achieve good practice. The structure will be concerned with the physical resources, personnel, organization, and climate in which health care is provided. The process will consider what happens between the professional team and the patient, together with attitudes towards care. Outcome will consider quality assurance and medical audit. Good practice in each of these will depend upon an effective educational programme.

Table 3. Checklist for practice review.

1.	Identify the elderly population of the practice from the age/sex register and carry out a review of their medical records
2.	Detail the arrangements for seeing old people in the practice and make sure these are appropriate
3.	Provide an information leaflet outlining the services of the practice for old people
4.	Determine a practice policy towards the elderly in general
5.	Make decisions about what form of anticipatory health promotion and prevention activities should be undertaken
6.	Consider offering assessments to patients entering long-term residential care
7.	Check the repeat prescription programme and make appropriate arrangements for regular review in the medicine taking of older people
8.	Review arrangements for the care of patients when they have been discharged from hospital
9.	Formulate a policy for reviewing the needs of the carers of elderly persons
10.	Undertake quality assurance exercises on the care of elderly persons
11.	Build up a network with other organizations concerned with the care of elderly people, for instance voluntary bodies, self-help groups
12.	Be aware of opportunities for further training and education for general practitioners and other professionals in the practice
13.	Check that adequate ancillary help is available in the practice so that full services are available to elderly people
14.	Arrange for follow-up of elderly patients seen by deputizing services

6.2 Structure

6.2.1 *Access*

Some old people keep away from the surgery because they do not want to 'bother the doctor'; but many have disabilities which make physical access to medical care difficult. A welcoming atmosphere, a properly furnished and heated waiting room, a downstairs consulting room and special toilet facilities for the disabled are features which will encourage an older person to visit the doctor. Good access by wheelchair and convenient public transport will also be an advantage, but may not be within the power of the general practitioner to provide. It might be possible to arrange alternative forms of transport, for instance by using a special car service, or by seeking the help of a voluntary organization. An understanding attitude by practice staff is important. Old people sometimes find it hard to describe their illness: a 'cold' can mean a severe chest infection.

6.2.2 *Appointments/open surgeries*

A small survey can ascertain whether existing arrangements for seeing the doctor are suitable for older people. Local bus services and the availability of telephones will influence whether older people prefer appointments or open surgeries. Because of multiple problems, old people may wish to combine their visit to the doctor with visits to other members of the primary health care team. Part of the survey can ascertain the extent to which old people are aware of the services which are directly available to them, as well as through referral by the general practitioner. Direct access to a practice nurse is found to be helpful by old people. Arrangements are likely to vary according to local circumstances and tradition. Some old people may find busy waiting rooms and modern telephone systems difficult to negotiate. Old people sometimes need longer consultations. One solution could be the creation of a special session for old people; but some may resent being stigmatized as a separate group. All practices now have to produce practice leaflets and these can provide information specifically aimed at old people and how they can best make use of the practice facilities.

6.2.3 *Information systems*

The clinical record is just one part of an information system which can allow the efficient use of practice resources. The records of older people often need restructuring. This can occur on their 65th birthday. Summary cards and medication details can then be made. A practice policy can be agreed for the creation of a database for each elderly person (Jachuk and Mulcahy, 1987). This approach enables each consultation to be used for opportunistic screening for older people (Freer, 1987).

In planning a programme of anticipatory care, the creation of an age/sex register is the first essential step. This is effective as a manual system, but the introduction of computers into general practice allows for more sophisticated information systems, including the creation of prescribing and morbidity registers. These together with an attendance register can be used to identify elderly people who require active follow-up and detailed health assessment. It is necessary to ensure that a system of regular review of repeat prescriptions is in place.

It is also good practice to review an elderly person when he/she joins the practice. Asking elderly people to leave the list and not accepting elderly people as patients on the basis of their age is unacceptable practice. However the needs of general practitioners in areas with very high numbers of older people have been insufficiently recognized.

6.2.4 *Home visits*

Careful consideration by a doctor is needed when an elderly patient asks for a home visit. There is a balance between the need to undertake necessary visits, and the need to encourage mobility and initiative amongst old people. Guidelines about when home visits are likely to be necessary and a checklist of possible items for consideration during a home visit are given in Tables 4 and 5.

Table 4. Home visits.

Home visits are likely to be necessary when:
• The patient is too ill to visit the surgery
• There are carer problems
• The patient is discharged from hospital
• The visit is requested by a nurse, physiotherapist or other professional carer
• The patient has recently been bereaved
• Home conditions need review
• Continuing care is needed.

Table 5. Guidelines for home visits.

• Assess the whole situation, including care provision, the environment, nursing needs and rehabilitation
• Assess need for further visits
• When nursing care is available and carers are present, consider the use of an 'intensive care unit' in the home
• Reassess at appropriate intervals
• Guard against producing unnecessary dependency
• Involve patients in decision making and share decisions with carers
• Use domiciliary consultant services effectively
• Use hospital admission for short-term and respite care where caring facilities are not available, or under stress
• Assess functional ability

6.2.5 *Staff*
It is necessary to have a full complement of practice and attached staff. Continuing education, either 'in-house' or by attendance at courses on care of the elderly, is important in modern practice.

6.3 Process

6.3.1 This section is concerned with the process of care. In seeking to achieve good practice for old people, it is important to recognize that different groups have different needs. Until extreme old age (over 85 years), most old people are healthy; a sizeable minority have hidden health problems; a smaller group are affected by acute illness; and a number are disabled owing to severe chronic illness. The whole spectrum of general practice care is therefore needed: acute, continuing, anticipatory, comprehensive, resettlement, terminal, nursing home and community hospital. The advocacy role of the general practitioner is still important. Personal doctoring is now extended to include contributions from the whole primary care team, and this should be encouraged. Informal carers are now seen to be of crucial importance, and deserve special care themselves. Each practice will need to review its policy in each of these aspects of care.

6.3.2 *Acute care*
Responding to patients' requests for help and the management of acute problems are of prime importance in general practice. Much of a doctor's time is taken up in providing this type of care, and it clearly has priority. The consultation, whether in surgery or at home, lies at the heart of all general practice. The four areas which form part of a consultation in general practice as outlined by Stott and Davis (1979) remain important when dealing with elderly patients. These include identification and management of presenting problems; modification of the patient's health-seeking behaviour; management of continuing problems; and opportunistic anticipatory care. Other important aspects are listed in Table 6. Frail elderly people may be functioning at the limits of one or more body systems. Disturbances such as infection or injury, which would create minor problems in a younger person, may have devastating consequences in an older person. Prompt assessment and treatment is essential. This means more frequent home visiting when looking after older people. Close co-operation between the general practitioner and geriatrician in sorting out problems at an early stage is clearly important.

6.3.3 *Continuing care*
The way in which continuing care is provided for older people requires careful planning. With better transport provision and better access to surgeries and health centres, regular visiting of older people at home has declined. This may not be an advantage because the effects of chronic illness on function may not be immediately apparent in the consulting room. There is still therefore a place for home visiting of patients who

Table 6. Acute care.

• Make accurate diagnosis and use appropriate treatment
• Understand atypical presentations and changed responses to illness
• Communicate effectively
• Give information to carers
• Consider the social implications of the illness
• Understand and use the skills of others in the community
• Explore patients' ideas about their illnesses
• Give advice clearly and, if necessary, in writing
• Clarify and reinforce advice
• Assess ability to undertake the activities of daily living
• Give precise information on follow-up arrangements
• Use drugs with care.

are affected by chronic illness. However, many medical problems do not necessarily impair functional ability: for example, epilepsy and thyroid disease. The continuing care of elderly people with these conditions is the same as for the rest of the population. Other diseases such as ischaemic heart disease and neurological disease usually do have associated disability, and patients with these conditions require regular review and functional assessment. Practice nurses can often undertake this type of care. It is important that there should be clear objectives for review appointments, whether they are in the surgery or in the patient's home, and there should be good channels of communication between the different providers of care. Construction of specific protocols for each disease can be helpful. The College is producing packs which include examples of such protocols.

6.3.4 *Anticipatory care*

6.3.4.1 *Theoretical background:* Prevention and surveillance are increasingly important aspects of general practice (RCGP, 1987). Regular visiting of the frail and housebound elderly has been a feature of general practice for a long time. Out of this has grown the concept of anticipatory care. It is necessary for such care to be systematic if it is to be successful. Unfortunately confusion about terminology has tended to obscure the aims of this activity.

- *Primary prevention* means stopping the disease before it has had the chance to arise; for example, immunization.
- *Secondary prevention* means the detection of disease at an early or precursor stage when it is asymptomatic and often curable; for example, cervical cytology.
- *Tertiary prevention* means the early recognition and *seeking out* of established symptomatic disease so that treatment or social support can be initiated to improve the quality of life and reduce the functional handicap produced by that disease.
- *Case finding* is tertiary prevention carried out opportunistically; it includes early detection of physical, mental, social and family disease or dysfunction.
- *Anticipatory care* means all types of prevention, and at the same time health promotion and education input. This is usually undertaken during normal patient contact.

Scope for primary and secondary prevention in the elderly is limited. It is recommended that older people with chronic respiratory problems should be immunized each year against influenza (Chief Medical Officer, 1989). Older people who have not previously been immunized against tetanus should receive this. The search for presymptomatic disease in the elderly is superficially attractive but has not been found to be beneficial. The Forrest Report (1986) did not, however, exclude making breast screening available on demand for older women, and a recent report (Fletcher, 1990) sees no reason to exclude women aged over 65 from screening for cancer of the cervix. Health promotion activities such as advice on sensible eating, smoking, alcohol consumption, weight control, accident avoidance, and exercise would seem to be very appropriate. Emphasis on anticipatory health care programmes should not undermine the prevention potential of good reactive care of older people.

The rationale behind tertiary prevention in old age is based on the tendency for old people to under-report illness. Evidence that this occurs is still being produced (Ebrahim *et al.*, 1987). The reason is inertia – often due to lack of information. Symptoms are attributed to old age itself and therefore not thought to be amenable to treatment. Professionals and relatives often collude with this. Often the pathology is minor, but multiple, and this in the elderly can quickly give rise to loss of function. The aim therefore of tertiary prevention in the elderly is to identify and alleviate established disease (albeit minor) at an early stage in order to improve or maintain functional status. The important point is to prevent disability and subsequent handicap, rather than the impairment itself (Table 7).

What evidence is there for the effectiveness of tertiary prevention in the elderly? There is a good deal of evidence which shows that screening old people demonstrates unreported need, and recent studies have confirmed earlier work (Vetter *et al.*, 1984; Tobias, 1988; White and Mulley, 1989; Anand and Court, 1989). Whether this is worth identifying is still unclear. The uncertain results produced by follow-up studies on screening exercises have led to the belief amongst doctors that because health benefit has not been demonstrated, the reverse is true. However, looking at the studies which have been done, there is indication that tertiary prevention has value. Both the studies of Lowther *et al.* (1970) and Williams (1974) found improvement in about 23% of their cases of follow-up. Lowther pointed out that early detection reduced the period of suffering in many conditions, and avoided hospital admission. Tulloch and Moore (1979), however, found that screening made no significant impact, although patients were kept independent for longer, and there was also a decrease in the expected stay in hospital. Vetter and colleagues (1984) reviewed the effects of health visitor anticipatory care in both rural and urban practice. They showed that the urban health

Table 7. Definitions.

Impairment Any loss or abnormality of psychological, physiological or anatomical structure or function
Disability Any restriction or lack (due to an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being
Handicap A disadvantage resulting from an impairment or disability that limits or prevents the fulfilment of a role (age, sex, social and cultural factors)

Source: World Health Organization (1980) *International Classification of Impairments, Disabilities and Handicaps.* Geneva, WHO.

visitor significantly increased the services to the elderly, and reduced their mortality but not their morbidity. They specifically commented that the quality of life of the elderly people was improved. The rural health visitor, on the other hand, had no such effect. Hendriksen and colleagues (1984) undertook a three-year randomized controlled trial in Copenhagen, where patients over 75 were given social and medical assessment. In the study group there was a significant reduction in mortality. Patients were thought to be better motivated about health and more active and self-confident as a result of this care. Another randomized controlled trial carried out in the USA by Rubinstein and his colleagues (1984) involved assessment of patients in hospital. The study patients had significant lower mortality, were significantly less likely to have been discharged to a nursing home than their own home, and were more likely to have improved functional status than the control group during the study period.

There is obviously no clear answer to the effectiveness of screening elderly people on health status, but this may not be the purpose of an anticipatory approach. In primary and secondary prevention success is measured in terms of cure or complete avoidance of disease. If these criteria are applied to tertiary prevention, then it is unsuccessful and not worth carrying out. But that is not the whole story. If the objective of tertiary prevention is re-examined, it is clear that it is not cure, but rather alleviation of the symptoms and the preservation or improvement of function. All the evaluative studies undertaken have examined as the significant outcome measure the cure or improvement of disease; yet each also commented on improved quality of life, reduction of suffering, and the fact that the patients have been more active and self-confident after such an assessment. All this points to improved functional ability, although little weight was attached to this finding, despite patients themselves often commenting about it. It would appear, therefore, that the wrong outcome measure has been studied. Unfortunately in the United Kingdom with the introduction of contractual preventive checks of old people by general practitioners, this research will be most difficult to undertake.

The aim of tertiary prevention is to alleviate symptoms and to prevent handicap by preserving or improving function which is normally measured in terms of ability to undertake activities of daily living; the hoped for effect is improved quality of life.

Clearly during tertiary screening if a disease is found which is curable, so much the better. This is part of normal practice: in all medical contact, prevention and acute care are involved simultaneously. Certainly in general practice and especially with the elderly it is impossible to separate out different types of care; this points to the importance of an opportunistic attitude towards the provision of preventive care. Social input can be equally effective as medical input in preventive care, for instance an old person unable to shop because of poorly placed housing can resume this activity if moved to a residence more conveniently placed.

The way in which tertiary prevention is undertaken will depend on the practice and the team. Over the past twenty years several methods of providing anticipatory care for old people have been developed. What has emerged is a list of possibilities (Table 8). Most of these have variations in practice.

In *Preventive Care of the Elderly: A Review of Current Developments* (Taylor and Buckley, 1987), ten different approaches to anticipatory care are described. The particular method selected by a practice will depend upon local factors: the number of older people in the practice, the interest and availability of members of the primary care team, and geography. The requirements of the new contract are the bare minimum and will be discussed later.

To do nothing or merely to undertake record reviews are still options in the contract; the effect will be to reduce remuneration. It is possible to invite old people over a certain selected age to attend for full assessment, either by providing well elderly clinics on a continuing basis or to have periodic screening campaigns. In some parts of the country lay volunteers have been used to assist in this type of activity (Tulloch, 1987; Carpenter *et al.*, 1987). Alternatively, this can be done selectively to certain at-risk groups (Taylor *et al.*, 1983). These methods effectively mean comprehensive assessment. More realistically, a two-tier approach can be used. This could involve using a screening letter (Barber *et al.*, 1980), asking a nurse or health visitor to undertake case-finding visits (Barley, 1987; Luker, 1987), or doing opportunistic case-finding at doctor/patient contact (Freer, 1987); the purpose is to identify problems and, if necessary, proceed to comprehensive assessment as a second stage.

Selective screening is unlikely to satisfy contract requirements. Should a practice wish to extend its preventive activities to include those between 65 and 75 years, a postal survey may well be appropriate.

6.3.4.2 *New contract:* The new contract for general practitioners includes specific requirements for health checks of elderly patients. There is little guidance as to what the objectives of these checks are, and it may be that it will turn out to be a very variable service. The risk of the new arrangements diverting time from other opportunities for improving the health of old people is real, and should be noted.

Table 8. Anticipatory care possibilities.

1.	To do nothing except provide normal service or undertake record review
2.	To undertake comprehensive screening of all over 75-year-old patients in a practice
3.	To provide selective screening for specific at-risk groups (e.g. the bereaved, those over 85 years)
4.	To undertake a postal survey followed by an offer of full assessment for those found to be in need
5.	To rely on health visitor or nurse case-finding visits followed by an offer of full assessment if necessary
6.	To carry out opportunistic case finding at doctor/patient contact, followed by an offer of full assessment if necessary

However, this report presumes that what is intended is that these checks should be the tertiary preventive part of anticipatory care. It is stipulated that each over 75-year-old patient be offered a visit and have certain checks carried out at yearly intervals (see Table 1). The implication is that these checks will be the first part of a two-tier *assessment* process, although this is not spelt out. The checks are analogous to a case-finding visit or postal questionnaire which alerts the team to patients who are vulnerable in some respect and need full assessment. The initial visit can be undertaken by the doctor (there is already a high level of doctor visiting in this age group), practice nurse, or some other professionally qualified person, but it is likely that in most practices the nurse will do this visit and the checks, with the exception of medication review. An agreed checklist will be helpful in this respect (see Appendix 1). The general practitioner will review the medication opportunistically, either in the surgery or at the patient's house. Doctor and nurse will then review the findings and decide whether full assessment is needed, what action needs to be taken and the timing of the next review. A database can then be constructed from the checklist and put into the patient's notes. The part played by practice nurses needs to be carefully thought out. Their contribution will be invaluable as often there are nursing implications. Adequate training, proper understanding of responsibilities and what is delegated, and a satisfactory contract are necessary for effective teamwork (see Appendix 1).

The full assessments will need to be multidisciplinary and will significantly increase the workload of the general practitioner and team. An increasing number of frail elderly also means that adequate facilities to deal with the problems found during these assessments must be available through hospitals and social services. Patients in nursing homes and rest homes who are over 75 years old will also get a yearly check, which apart from being beneficial to the patient will also be of value to home staff and social services departments.

The new contract therefore lays down the basis of an opportunistic case-finding programme. Health education as an essential component of anticipatory care needs to be added in order to give it real meaning.

6.3.4.3 *Functional assessment:* Although general practitioners are accustomed to assessing patients' problems in physical, psychological and social terms, a formal systematic training in functional assessment of an old person remains exceptional. This is unfortunate because there is a strong link between illness and independent social well-being, as measured by the ability to perform activities of daily living. Activities of daily living can be considered at three levels: ability to relate to the outside world, ability to undertake domestic tasks, and ability to undertake personal tasks. These are usually listed separately, but if they are represented as concentric rings surrounding the person, the dynamic relationship between each level is appreciated (Figure 3). For personal autonomy, each ring needs to be intact; functional deterioration tends to start at the outer ring (sociability), proceeds to the second ring (domestic), and finally to the inner ring (personal). Function at all three levels can be affected by illness, and deterioration in the ability to perform any of these activities may be an early indication of incipient illness.

The model provides a useful checklist and takes into account the timing of functional deterioration, and is useful in identifying decline. More importantly, the process is reversible: dealing with the illness or arranging for a social service often restores ability at each level (Williams, 1986). *Assessment of function therefore needs to be an integral part of the clinical assessment of an old person, and is helpful both in diagnosis and in planning appropriate therapy.*

6.3.4.4 *High risk groups:* There has been for some time the assumption that some groups of elderly people are particularly at risk. The risk is not associated with susceptibility to certain diseases, but to impaired physical, mental and social functioning. This is seen in reduced capacity to self-care, and the potential need for various forms of domiciliary or institutional care.

Most surveys have identified the very old (over 80) as an at-risk group. The World Health Organization (1977) added several other groups including the recently widowed, the never married, those living alone, those who are socially isolated, those without children, and those in poor economic circumstances. Taylor and colleagues (1983) further extended the list by including those recently discharged from hospital, those who had recently changed their dwelling, the divorced or separated, and those in social class 5 (Registrar General's classification).

In an interesting study, Taylor and Ford (1983) critically examined the extent and nature of risk disadvantage of these 11 groups. In their summary they identified three categories of those at risk. The first were those minimally at risk, which included the isolated, the never married and to a lesser extent, the childless. The second, who were more at risk, included the recently widowed, those living alone, the poor, and those in social class 5. The third category consisted of the recently moved, the recently discharged, the divorced or separated, and the very old, and these are considered to be the group at greatest risk.

What effect should these findings have on good practice? With the new contract arrangements it will be possible to identify people in each of these categories, and make a note of this on the records. Specific attention will need to be given to social and welfare requirements, especially in the group which were considered to be at greatest risk.

An important subgroup of the elderly are those belonging to the ethnic minorities. An increase in their number is predicted and little is known about their health needs. A survey of elderly people born in India and Pakistan showed that over half those aged over 75 years were not fully independent in the basic activities of daily living (Donaldson, 1986). Communication problems are likely to exist if the first language is not English and this probably contributes to the under usage of services by this group (Kalsi and Constantinides, 1989). Doctors will need to identify such patients on their list and will probably liaise with community workers in seeking special needs.

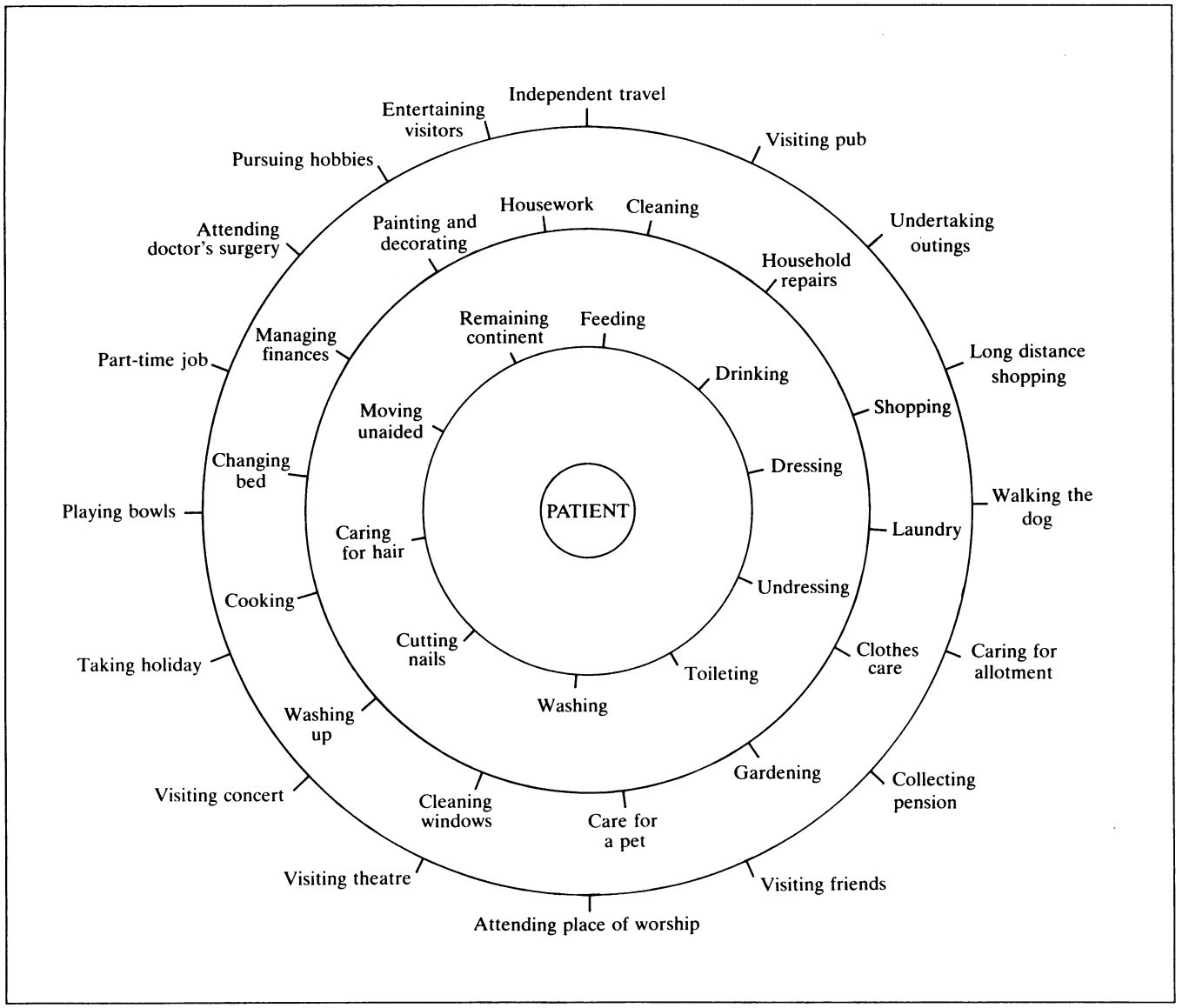

Figure 3. Social performance levels (elderly persons).

Source: Williams (1986). Reproduced with permission of the Editor of the *British Journal of General Practice.*

6.3.4.5 *Recently discharged patients:* Discharged hospital patients were found by Taylor and Ford (1983) to be very disadvantaged, and this has been confirmed by other workers (Graham and Livesley, 1983; Victor and Vetter, 1985; Williams and Fitton, 1988). Difficulties occur following discharge from hospital because of inadequate planning by the hospital and poor response by community services. Hospitals clearly need to make adequate arrangements for discharging elderly patients and a list of guidelines is given in Table 9. It is also important for there to be clear practice policies about who will make contact with the patients once discharged. An elderly person discharged from hospital should be considered for a visit within two days by someone in the primary health care team.

The initial visit will include checks of medication, advice given by hospital, the services organized, follow-up arrangements for further hospital visits, and most importantly, the needs and availability of carers. Plans for further visits should be explicitly agreed with the patient and arrangements for taking and ordering of continuing medication implemented. Older people may not appreciate that they may be eligible for welfare benefits such as an attendance allowance, and the post-hospital visit from the practice may be an appropriate time to discuss this.

Williams and Fitton (1988) described reasons for early readmission. The principal reasons included relapse, development of a new condition, carer problems, medication problems, service problems, unplanned terminal care and complications. There were also contributory reasons and special circumstances where early readmission was more likely. The list of these gives an idea of patients who are at risk in general, and their presence should be noted as part of an anticipatory care programme. They include: the very confused, those on low income, high levels of previous admission, those with carers who had concern about their own health or

Table 9. Guidelines for the hospital when discharging patients.

1. Assess home circumstances
2. Check on carers
3. Give adequate warning to relatives and carers of the discharge
4. Ascertain that discharge is appropriate
5. Assess the patient's ability to self-care at home
6. Arrange transport so that the patient can get home during the day
7. Ensure advice is understood by the patient or carer, or both
8. Confirm arrangements for services
9. Check that some professional in the community knows that the patient is being discharged
10. Ring the general practitioner's surgery with brief details
11. Be aware of special circumstances where early re-admission is possible
12. Check that patients and carers understand about the medication
13. Give appropriately labelled and easy-to-handle bottles and containers
14. Give a 10-day supply of a drug with instructions to let the general practitioner know of a repeat prescription
15. Give verbal and written instructions to carers, especially when patients are confused
16. Take account of the patient's health before dispensing so that problems associated with confusion, arthritis and immobility can be foreseen
17. Have a checklist to go through with the patients about important instructions

a high frustration level, carers who are engaged in personal tasks, for example washing and dressing, faecal incontinence, communication problems between patient and carers, and poor mobility.

Other possible indicators of risk were patients who were taking over five items of prescribed medication, patients with carers who were not spouses, and patients who had been living in their present accommodation for a relatively short time.

6.3.5 *Older people in residential and nursing homes*

The last ten years has witnessed a rapid growth in the number of private rest homes and nursing homes, in part due to demographic trends but also to the use of public funds to finance eligible individuals in the private sector. This has significantly affected the workload of many general practitioners, particularly in some rural and coastal retirement areas. A further point of contention has been the lack of formal input from general practice to the planning and registration process.

However, if legitimate concern for these trends is not to be misinterpreted as a lack of commitment to the care of older people, it is essential that general practice presents constructive suggestions regarding general practitioner involvement with private homes.

First of all, and especially with larger homes, primary care could be provided by one doctor similar to a hospital clinical assistantship. The potential for continuity and consistency of clinical policies offers clear advantages. Such an arrangement could be financed by a retainer fee and guidance on these is available from the General Medical Services Committee (Table 10). One problem with this arrangement in urban areas is that it limits choice of general practice for the residents and for some it would mean a change in general practitioner. Clearly private home operators would

Table 10. GMSC guidance on duties for which retainers can be accepted.

Advice to management on:

- arrangements for the provision of services by district health authorities, family practitioner committees, Department of Health
- services by voluntary organizations
- arrangements for storing and distributing pharmaceutical products
- disposal of general and clinical waste
- patient record systems
- all aspects of confidentiality
- medicolegal affairs
- matters concerning advertising and promotion of nursing homes
- any other matters where a medical opinion is required

Action in support of management:

- liaison with other doctors and professionals who provide services to patients in the home
- liaison with local authorities and district health authorities on matters affecting the registration and inspection of the home
- on matters relating to notifiable diseases and advice on the appropriate action
- on provision of an occupational health service
- on staff appointments
- on staff training

Medical duties

- organizing an immunization policy
- preparing medical reports for third parties
- providing medical services to residents who do not wish to receive NHS provision

Source: General Medical Services Committee (1987) *Annual Report*. London, GMSC.

benefit from discussing these matters with local general practitioners, as early as possible.

General practice for its part has to accept the existence of private homes for the elderly and indeed the likelihood that current Government legislation may encourage further growth in the private sector. What is needed is an agreement on the objectives and standards of good primary medical care for older people living in residential or nursing homes.

The following features of care are suggested for consideration by general practitioners with a significant involvement in this type of care:

- *Attitudes.* To counter 'ageism' as much as possible and contribute to the demedicalization of the institutional environment that is happening in many of the better private homes.
- *Visiting arrangements.* To organize regular visits to the home and not just respond to requests to visit.
- *Clinical policies.* To work with the home staff in developing agreed management plans for common problems.
- *Proactive care.* To ensure that visits do not deal solely with presented problems but also incorporate a proactive element and include, for example, regular case reviews.
- *Drug reviews.* To make the supervision and review of residents' medication a priority. The Royal Pharmaceutical Society (1989) has produced guidelines.
- *Records.* In addition to the NHS records, to contribute to the home records so that the general practitioner care and treatment of residents are clearly stated for the use of house staff and other visiting medical staff.

Not only would attention to these aspects of care provide a high standard of service, but by its efficiency and continuity it would also have a positive effect on the workload generated by the home. It is also likely that the screening requirements for over 75-year-olds will be much more easily and quickly fulfilled for residents of homes than for patients living in their own homes.

6.3.6 *The dying patient*

The care of the dying is the final service provided by general practitioners to their elderly patients. Although most people now die in hospital or hospices (65% in the age group 65-74 and 76% in the age group over 75; OPCS, 1989), general practitioners continue to be involved in providing care during the terminal illness of their patients. It is important to allow the patient to die with dignity in familiar surroundings, if it is their wish. The principal aim of the doctor is the alleviation of distress. This means not only adequate relief of pain, but also help with other symptoms and with psychological distress. Support for the patient will include support for their families and carers. Sensitive communication and reliability are essential: good terminal care is about personal contribution of time. The family doctor is in the best position to co-ordinate the available community services. District nurses, Marie Curie nurses and MacMillan nurses may all be able to contribute to providing the dying person and their family with the choice of dying at home or in a hospice or hospital.

6.3.7 *Carers*

The family is still the most constant and reliable support for the elderly person (Jones *et al.*, 1983). This help, however, in extreme old age is often extended and may be provided by neighbours, friends and even lodgers. The important carers are those who provide day to day care, not relatives who live a distance away and only turn up sporadically. Carers want and need practical help in caring for their elderly charges. If this is provided, most gladly continue their support.

The problems faced by carers are well documented (Isaacs *et al.*, 1972; Sanford, 1975). Where the patient is the spouse they include: advanced age, problems with their own health, physical difficulties with nursing, concern about safety, aggressive behaviour, poor communication, incontinence, lack of knowledge of the nature of the illness and its prognosis. Where the carer is another relative or friend, they include also the needs of their own families and other personal commitments.

Good practice for general practitioners means recognizing that families and carers of elderly patients need support themselves. Practically this involves:

- Balancing the needs of both patient and carers. It is rare for the family to be in conflict. If this occurs objectivity is necessary with the patient's welfare being the prime responsibility of the doctor.
- Communicating to carers details of the illness, the medication and the prognosis. Problems with information sharing and confidentiality may arise, but this is not common in practice. A more common ethical dilemma is when the relative's and patient's wishes differ and the relative attempts to enrol the support of the general practitioner.
- Responding to carers' cries for help. In old age some problems develop quickly and have to be treated urgently. Other conditions such as dementia are insidious: the problems caused by this illness may appear innocuous on the surface and yet be causing considerable stress to the relative.
- Recognizing signs of strain in carers. Some problems are poorly tolerated. They include sleep disturbance, wandering, incontinence, physical dependence, impaired communication and behaviour problems. If these are present a special watch should be made for signs of breakdown in support. Depression and anxiety are common among carers of elderly patients.
- Taking necessary steps for support of carers at an early stage. These would include: effective management of an old person's illness and improving functional status; arranging adequate support in the home, for instance home help or self-help groups; arranging for patients to spend some time away in day care or hospital respite admission; and emphasizing doctor availability, nursing and counselling care.

- Identifying prime carers of elderly patients before crises occur and noting their names in the patient's records. This information requires to be reviewed regularly. Apart from identifying the patient's prime supporter, checking if there exists a wider network of relatives and friends who might be helpful in a crisis.
- Providing the patient and carer with full information about the facilities of the practice and health care team, and the range of other services which are available.

It is perhaps too easy for general practitioners and relatives to slip into a combative relationship. In part this is due to the guilt experienced by relatives, and also to the inherent criticism felt by the general practitioner. Ideally relatives should feel able to contact general practitioners directly without feeling that they are being troublesome, and general practitioners should make it clear that relatives should feel able to contact them about their concerns. Another common fault is the collusion of low communication between doctor and carer, which essentially excludes the patient and can add to his suffering.

6.3.8 *Advocacy*

Old people in the community are not a homogeneous group, but rather a group of individuals with the same human value, but different needs, aspirations and expectations. Service provision to the elderly, because of its complex nature, may not always reflect this. There are times, therefore, when general practitioners and professional workers have to act as the patient's advocate, when needs are not being met effectively or when the patient or family is being exploited. An elderly patient has the same rights and responsibilities as any other person. Individual wishes should be accommodated and providers should always involve the person concerned. Cultural differences should be recognized, choice made possible, and information provided. It is necessary to look at situations through the eyes of the old people concerned before making decisions or taking action. The provisions in the new contract may involve invasion of the privacy of old people.

6.3.9 *Attitudes*

The structure of primary health care not only includes physical resources and available personnel, but also the climate in which health care is provided. Concern has been expressed earlier in this report about the ambivalent attitudes of members of the primary health care team towards working with older people, and the low expectations which many older people have about their own health. These are particular aspects of a more general problem. Negative stereotypes of old age and older people appear to be widely held in our society (Lutsky, 1980). They need to be counteracted by a positive approach in teaching health workers at all stages in their careers. Almost all older people are positive in their response to being invited to participate in case-finding programmes in general practice, and one of the benefits of this activity is the change in expectations which can be seen in older people.

Although general practitioners may feel unable to change negative attitudes in general towards old age, within individual practices much can be achieved by example and by organizing educational programmes about the care of the elderly for members of the primary health care team. The realization that many of the illnesses which affect old people are amenable to treatment is a powerful antidote to the view that old people are affected only by degenerative diseases which cause unremitting deterioration in functional abilities.

6.4 Outcome

6.4.1 *Introduction*

Little attention has been given in the past to the measurement of outcome in general practice. There is now widespread recognition that the systematic evaluation of the effectiveness of health care is necessary. This view is shared by the medical profession and the Government. Many general practitioners are already providing high levels of care and medical audit will reinforce good practice as well as identify gaps and weaknesses in the services provided.

There are difficulties in devising methods of medical audit which truly reflect the outcome of care. Much activity in this area examines the processes of care in the hope that good practice is associated with good outcome. In the elderly patient satisfaction is a good measure of outcome, since the maintenance of a high quality of life is a major aim of health care. However, health care has only a limited impact on indices of life satisfaction, and the low expectations of health by older people may lead them to express high levels of satisfaction with health care which is only mediocre.

6.4.2 *Quality assurance and medical audit*

There is no doubt that quality assurance will become an integral part of all health care, with general practitioners obliged to participate with medical audit. The purpose of quality assurance is to examine existing practice. This means defining standards of good care, testing the extent to which they have been achieved, and facilitating improvements. Participating in medical audit will become the core of continuing medical education for general practitioners.

The first step in quality assurance is the acceptance that it is necessary to review standards of care. It is sensible to start in a simple way with information which is readily available. An example could be an examination of repeat prescriptions issued to patients aged over 75. After defining criteria for good practice, reviewing the gathered information with colleagues is likely to lead, for instance, to questions about the way in which older people with chronic illness are treated and monitored. These questions can then form the basis of a more focused audit of care for selected groups of older people. This may lead to the creation of agreed practice protocols for the management of chronic conditions such as post-stroke problems, diabetes and obstructive airways disease. Anticipatory care will also be a fruitful subject for medical audit.

6.5 Education

6.5.1 Education on health care of the elderly must be appropriate. Although hospital-based geriatric medicine has a great deal to offer the future general practitioner in learning about management of disease and rehabilitation, there is also a great deal to be learned about the care of the elderly in the community that is different. The current educational balance needs to be re-assessed. All medical schools now include health care of the elderly and general practice in the undergraduate curriculum. At vocational training level the situation is more confused. A six-month SHO post in geriatric medicine is helpful, but a general medicine post may be just as good. The Diploma in Geriatric Medicine is designed for those entering general practice and may form part of the higher professional training for that discipline. The College has an important role in ensuring that vocational training and continuing medical education addresses the issues of community care for old people. This report is full of educational opportunities which need to be taken.

6.5.2 The educational needs of practice-based staff and members of the primary care team also need to be addressed. Special courses need to be designed for this purpose. Practices need to ensure that staff have adequate time available for such in-service training. It is of crucial importance that members of the team, for instance practice nurses, have the necessary experience and training for undertaking delegated responsibilities. It is hoped that this report will help those who have to plan educational activities in continuing education for both general practitioners and members of the team.

7. CONCLUSION

7.1 An important question facing general practice is how to determine priorities. The new contract and White Paper will inevitably increase pressures: the need to attract more patients to maintain income, to achieve targets, and to undertake medical audit. Additional administration and budget management will all make demands on time. The elderly compete with other groups of patients for resources, and a case will have to be made for any special attention they receive. The dangers of raising patient expectations when resources are not available must be noted.

7.2 The working party considered whether it should recommend that general practitioners should provide only a minimal service for elderly patients: for example, a demand-led response providing only acute care, leaving other services like anticipatory care, continuing care and nursing home care to hospital outreach or other services. This was rejected and a comprehensive service is recommended. General practitioners can really do no other than accept that elderly patients should receive the full normal range of services (RCGP, 1987).

7.3 The elderly have particular needs which have implications for the way in which health care can best be organized. Many practices have introduced interesting ways of caring for their elderly patients (Taylor and Buckley, 1987). Examples of good practice are a powerful motivation to others. Peer review is an essential ingredient in medical audit and the enthusiasm with which proposals on this have been taken up by the profession bodes well for the future.

7.4 When caring for elderly people, a team approach remains vital. Many professional skills are needed. The general practitioner's position in the team will continue to be of first importance, because of the frequency of contact, availability and contractual obligations. When considering the merits of whether services to old people should be practice based or patch based, in general a practice-based service is seen as preferable, in that it preserves choice for the patient. A redefinition of some roles within the team, for instance health visitors and district nurses, appears likely following implementation of the Government's proposals for the National Health Service. Detailed discussions with the representatives of other disciplines will be needed to achieve an effective primary health care team.

7.5 Who should assess the health and social needs of the elderly in the community, particularly those patients considered for long-term residential care? *Caring for People* (Secretaries of State, 1989b) advocates multidisciplinary assessment and the general practitioner and the primary health care team are in a strong position to contribute to these assessments.

7.6 The report frequently refers to the educational needs for general practitioners and other members of the team in achieving high standards of care for elderly patients. This is a matter of some urgency, and could be linked to the impetus given to medical audit in the White Paper. Research is also important if the health of old people is to be improved. The benefits of anticipatory care need to be evaluated. The health status of elderly patients in the community needs to be measured. The special problems of at-risk groups needs to be clarified. Alternative ways of providing community care need to be considered and experimental schemes assessed.

8. RECOMMENDATIONS

1. That the College accepts that old people have specific medical needs, and that these should be provided for as part of a comprehensive general practice service.
2. That the College encourages practices to construct a detailed policy for the care of old people.
3. That the College has discussions with organizations representing professions involved in caring for old people, for example health visitors, nurses, social workers, geriatricians and psychiatrists, in order to clarify their roles.

4. That the College examines urgently the educational implications of community care of old people for general practitioners and other members of the primary health care team.
5. That the College gives a high priority to supporting research involved with caring for elderly people in the community.
6. That services to old people should be practice-based and that fragmentation of such care should be resisted.
7. That it becomes College policy that general practitioners and other members of the primary care team should contribute to the assessment of patients entering long-term care. The College, however, should sponsor an educational initiative to make sure that general practitioners and members of the team have adequate skills to undertake these assessments.

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